spread of disease amongst the poor, as arguments for payment for medical care, it implies a lack of recognition of the very large, if not primary, role that other national activities play in the production of these statistics. Until it is politically and socially recognized that medical care is but one aspect of health, and that the creation of mechanisms for financing of medical care are not only an incomplete but possibly a wrong solution, will we begin to affect significantly some of the statistics that have been bandied about so easily.

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To the Editor: In the preamble of the constitution of the World Health Organization is an articulate, all-encompassing definition of health, namely, "Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."

I doubt that such a broad, and all-inclusive definition is realistically achievable today. Certainly it has not been accepted by all concerned, but it should serve as a challenge and be looked to as an ultimate goal.

The House of Delegates of American Medical Association in 1970 approved a definition that seems more realistic: "Good health is a state of physical and mental well-being."

As both definitions imply medical care truly is only one part of health care. It is the physician who is totally responsible for the former. Practically speaking health must be qualified by description because one may have poor or bad health. Most people don't realize the meaning of good health and many take it for granted. Only when it is lost can one appreciate its true meaning.

Health care will be a major issue in the 1972 Presidential election. Those of us in the private practice of medicine find ourselves in an unfortunate position of prominence because of this social problem.

Let us all—physicians, politicians, social planners, educators and others—remember that it is only the physician who can scientifically treat our people. But solutions toward improving the health care of our people must be shared between the private sector of society and government, and the components of the developing health teams. This joint input and balance will improve the effective delivery of a pluralistic health care system in the United States.

I do not intend to add to our welter of semantics, but in a very real sense there is even confusion in defining health and health care services. It appears that we as physicians are often guilty of this mistake. Health may be good or bad, and it is a physical, mental or social state dependent on genetics, environment, personal habits and health care services.

We hear a great deal about the "health team." Actually the health team is only a concept, and it is really not new. Our medical care system has always been built on teamwork, and a division of labor as evidenced by a steady increasing interdependence among professionals. The ever-increasing specialization of medical practice, a system of referrals, the use of consultants, as well as the interrelationship between the medical profession and members of the allied health professionals exemplify a team effort that maximizes available resources. Additional components of a cooperative approach are typified by allied health professionals in hospitals, the voluntary health workers, social and public health agencies.

The neighborhood health center is a primary experimental location for the operation of health teams, because the center is established to deliver a full range of health care services in a comprehensive and continuous manner in specific areas. In an effort to foster the health team concept, a coordinated interdisciplinary approach for the education and training of allied health personnel is being attempted by a number of universities throughout the country.

It appears that the health team will develop pretty much along the lines of the traditional individual health care services: The acute and intensive care teams; the extended care team; the rehabilitation and restorative teams; the more recently advocated disease prevention and health maintenance teams, and finally those teams dealing with the environmental aspects and ecology of health.

So it is in this context that "Health care is inescapably a community effort calling for comprehensive health services for everyone and, a personal physician who will provide the continuity of integrated medical and medically-related serv-

ices," as the National Commission on Health Services said in a report titled "Health Is a Community Affair."

It is imperative that a correct and proper evaluation and understanding of health care vs. medical care be developed. Medical care is a basic component of health. It represents the services performed by the physician, and those provided by allied health personnel under the direction of the physician and for which the physician is responsible.

In contrast, health care is a broad social responsibility involving the availability and accessibility of medical services provided in hospitals and other facilities. Personal hygiene and habits, housing, environmental pollution, sanitation, education, planning, food and nutrition, transportation—or the lack of such elements—constitute and affect the health care of a nation. One may then conclude that the responsibility for medical care is indeed that of the physician. But the social planner, the educator, the environmentalist, the public health worker and many others share in the associated responsibility for health care.

This of course leads to accountability of medical services and resultant statistics. For this the physician is also responsible. But when we consider health statistics, these are as much the responsibility of others.

This then leads to the current and perhaps improper trend to assess a nation's health system through statistics. It is here that I take issue.

To the practicing physician one of the most sensitive examples of misuse of statistics has been the attempt to use infant mortality figures as a basis for the assessment of our nation's health. We see such figures used as an index purporting to indicate the comparative state of our nation's health.

The variables in infant mortality and life expectancy are more symptoms of low economic conditions and cultural patterns than of the level of medical care provided.

It is unfortunate that in the United States such comparative statistics have often been used politically, comparing American mortality and longevity rates with those of other nations for less than scientific purposes.

Infant mortality is truly more a social than a medical problem. Such factors as poverty, malnutrition, poor housing, inadequate sanitation, low educational levels, and ethnic and cultural differences are more closely associated with infant mortality than are the number of doctors and hospitals or the level of care they provide.

When we consider that 70 percent of the deaths in the United States are related to cancer, heart disease and stroke, and only 2.2 percent of our deaths are due to infant mortality, the significance of the latter can be seen in its true perspective.

It is not generally stated, but comparisons of the United States' with Sweden's infant mortality is usually meant to imply that the United States system is deficient and we should adopt the Swedish health system. Since this is the most common comparative reference, it is interesting to examine other areas.

- Sweden has a population of eight million and the United States two hundred and five million.
- The United States covers 3.6 million square miles; Sweden about the same as our state of California, 175 thousand square miles.
- Sweden has an homogeneous population, the United States an extremely heterogeneous population by all measurements—ethnic, social, cultural and economic.
- The infant mortality rates in Minnesota and Wisconsin, where there is a high population of Swedish descent, are lower than Sweden's.
- The World Health Organization's *Demographic Yearbook* makes note that the figures *should not be used for comparison* because standards of measurements vary with nations.

In most countries, reports of births are the responsibility of parents, and since there is no punishment for not registering, a sizable percentage of infant deaths go unrecorded. In the United States the physician is responsible for certifying all births and deaths, and our criterion is "one heart beat is a live birth."

So if we were to use the same statistical source that Senator Kennedy used in speeches across the country, the United States could be said to have the best health care system because we had the lowest death rate due to bronchitis. France, too, could be said to have the best, because it had the lowest incidence of deaths due to peptic ulcer. And the Netherlands also could be first, for its death rate due to tuberculosis and pneumonia is lowest.

The point is that we must avoid a mix of

apples and oranges, particularly when we discuss a subject so important as the health of Americans.

A profound interest of the medical profession is that it have a system in which physicians can continue to provide the best possible medical care for all the people.

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To the Editor: Medical care, no matter how fine, comprehensive or responsive to equity needs, as well as speed of response, quality or efficiency, no matter what the cost, will not affect the health of Americans. Health is not the concern nor prime province of the medical profession, save in rhetoric and in preambles to legislative action.

Neither medical care nor health is solely the responsibility of the physician. Indeed one might historically (in an outlined form) trace the evolution of concern:

- The patients' cry of "I hurt" led to many persons of different bent responding to the cry.
- The physician, of all these, earned the right to intervene and respond to the cry.
- Science and technology increased the competence of the physician and his medical allies.
- At the same time, medical care became more complex and fragmented. More and more individuals and groups became involved in the professional arena.
- As society demonstrated that it could cope with meeting human needs of all kinds, aspiration levels increased.
- As the concepts arising from medicine's and society's complexity evolved, models of behavior became more and more concerned with interactions and transactions, ecology and social systems.
- Health became differentiated from medical care. Thus as the complexities of health become clarified, it is more obvious that it is related to the broader social issues: employment, poverty, housing, environment (physical and social) and innumerable other factors. It is not the absence of illness but is more closely related to the well-being of man and the quality of life.
- Since society had previously legitimized the physician's role in medical care, as health became a concern "in good currency," it transferred at the least the "rhetorical responsibility" to him without giving him the resource tools or real responsibility to perform.
- Medicine has from its perspective chosen to remain responsible for medical care, and *not* be involved in health.

What, then, is society demanding? A profession modifies and changes both as a result of internal developments (science, art and technology) and from society's pressures, emerging out of a vast number of social changes.

The increased aspiration by people for medical care reflects many things: increased communications, affluence, scientific development and the need to correct inequities of quality and the availability of care. Demands escalate as we demonstrate through research, or care of a few people, how high the quality of care by the medical profession can be. But the very complexity and fragmentation, in part stimulated by our national support system, provokes frustration in both physicians and patients. We all want a better job done.

The current demands for more money and national insurance avoid the key questions:

- How do you meet diverse demands and expectations of medical care to lower death rate, decrease morbidity, reduce disability, dissatisfactions and discomforts? Each group in the medical community, including the patients, has different priorities.
- Are there ways to deliver medical care by developing new systems – for example, group practices, ambulatory health centers, emergency services?
- Can the poor be brought truly into the mainstream of medicine and given first quality care, without excessive costs to consumers, providers or their party payers?

Society has taken a pre-Copernican position—if you deal with finance, all else will follow. This is not so.

To this end in a recent report to the Science and Technology Advisory Council of the State Legislature [of California] I supported the development of a pattern of local health authorities where *all* those involved in medical care